

ZUNG SELF-RATING ANXIETY SCALE:

Please read each one carefully and decide how much of the statement describes how much you have been feeling during the past week.

Check the appropriate period of time for how much time you have been feeling that way.

1. I feel more nervous and anxious than usual.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

2. I feel afraid for no reason at all.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

3. I get upset easily or feel panicky.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

4. I feel like I'm falling apart and going to pieces.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

5. I feel that everything is all right and nothing bad will happen.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

6. My arms and legs shake and tremble.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

7. I am bothered by headaches, neck and back pains.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

8. I feel weak and get tired easily.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

9. I feel calm and can sit still easily.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

10. I can feel my heart beating fast.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

11. I am bothered by dizzy spells.

- ☐ A Little of the Time
- ☐ Some of the Time

☐ Good Part of the Time
☐ Most of the Time

12. I have fainting spells or feel like it.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

13. I can breathe in and out easily.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

14. I get feelings of numbness and tingling in my fingers, toes.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

15. I am bothered by stomach aches or indigestion.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

16. I have to empty my bladder often.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

17. My hands are usually warm and dry.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

18. My face gets hot and blushes.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

19. I fall asleep easily and get a good night's rest.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

20. I have nightmares.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time

Alcohol Use Disorders Identification Test Screening Instrument (AUDIT)

Directions: For each item below, please indicate the answer that best describes your behavior.

	Never	Monthly or Less	2 to 4 Times a Month	2 to 3 Times per Week	4 or More Times a Week
1. How often do you have a drink containing alcohol?	☐	☐	☐	☐	☐
	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	☐	☐	☐	☐	☐
	Never	Less Than Monthly	Monthly	2 to 3 Times a Week	4 or More Times a Week
3. How often do you have six or more drinks on one occasion?	☐	☐	☐	☐	☐
4. How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	☐	☐	☐	☐	☐
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐
	No	Yes, But Not In the Last Year	Yes, During the Last Year		
9. Have you or someone else been injured as a result of your drinking?	☐	☐	☐	☐	☐
10. Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?	☐	☐	☐	☐	☐

Adult Self-Report of ADHD

Never Rarely Sometimes Often Very Often

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?

☐ ☐ ☐ ☐ ☐

2. How often do you have difficulty getting things in order when you have to do a task that requires organization?

☐ ☐ ☐ ☐ ☐

3. How often do you have problems remembering appointments or obligations?

☐ ☐ ☐ ☐ ☐

4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?

☐ ☐ ☐ ☐ ☐

5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?

☐ ☐ ☐ ☐ ☐

6. How often do you feel overly active and compelled to do things, like you were driven by a motor?

☐ ☐ ☐ ☐ ☐

ZUNG SELF-RATING DEPRESSION SCALE:

Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

Put a check in front of the appropriate period of time.

1. I feel down-hearted and blue.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time

2. Morning is when I feel the best.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

3. I have crying spells or feel like it.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

4. I have trouble sleeping at night.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

5. I eat as much as I used to.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

6. I still enjoy sex.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

7. I notice that I am losing weight.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

8. I have trouble with constipation.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

9. My heart beats faster than normal.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

10. I get tired for no reason.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

11. My mind is as clear as it used to be.

- ☐ A Little of the Time
- ☐ Some of the Time
- ☐ Good Part of the Time
- ☐ Most of the Time.

12. I find it easy to do the things I used to.

- ☐ A Little of the Time
- ☐ Some of the Time

☐ Good Part of the Time
☐ Most of the Time.

13. I am restless and can't keep still.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time.

14. I feel hopeful about the future.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time.

15. I am more irritable than usual.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time.

16. I find it easy to make decisions.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time.

17. I feel that I am useful and needed.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time.

18. My life is pretty full.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time.

19. I feel that others would be better off if I were dead.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time.

20. I still enjoy the things I use to.

☐ A Little of the Time
☐ Some of the Time
☐ Good Part of the Time
☐ Most of the Time.

MOOD DISORDER QUESTIONNAIRE:

Please answer each question as best you can.

1. Has there ever been a period of time when you were not your usual self and ...

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?

☐ Yes
☐ No

...you were so irritable that you shouted at people or started fights or arguments?

☐ Yes
☐ No

...you felt much more self-confident than usual?

☐ Yes
☐ No

...you got much less sleep than usual and found you didn't really miss it?

☐ Yes
☐ No

...you were much more talkative or spoke much faster than usual?

☐ Yes
☐ No

...thoughts raced through your head or you couldn't slow your mind down?

☐ Yes
☐ No

...you were so easily distracted by things around you that you had trouble concentrating or staying on track?

☐ Yes
☐ No

...you had much more energy than usual?

☐ Yes

☐ No

...you were much more active or did many more things than usual?

☐ Yes
☐ No

...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?

☐ Yes
☐ No

...you were much more interested in sex than usual?

☐ Yes
☐ No

...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?

☐ Yes
☐ No

...spending money got you or your family into trouble?

☐ Yes
☐ No

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

☐ Yes
☐ No

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?

Please check one response only.

☐ No Problem
☐ Minor Problem
☐ Moderate Problem
☐ Serious Problem

Bipolar Spectrum Diagnostic Scale (BSDS)

Directions: Please read through all the descriptions below before checking any boxes.

1. Some individuals notice that their mood and/or energy levels shift drastically from time to time. ☐
2. These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high. ☐
3. During their "low" phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things they need to do ☐
4. They often put on weight during these periods. ☐
5. During their low phases these individuals often feel "blue", sad all the time, or depressed. ☐
6. Sometimes during these low phases, they feel hopeless or even suicidal. ☐
7. Their ability to function at work or socially is impaired. ☐
8. Typically, these low phases last for a few weeks, but sometimes they last only a few days. ☐
9. Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, during which their mood and energy level feels "right" and their ability to function is not disturbed. ☐
10. They may notice a marked shift or "switch" in the way they feel. ☐
11. Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do. ☐
12. Sometimes, during these "high" periods, these individuals feel as if they have too much energy or feel "hyper". ☐
13. Some individuals, during these high periods, may feel irritable, "on edge", or aggressive. ☐
14. Some individuals, during these high periods, may take on too many activities at once. ☐
15. During these high periods, some individuals spend money in ways that cause them trouble. ☐
16. They may be more talkative, outgoing, or sexual during these periods. ☐
17. Sometimes, their behavior during these high periods seems strange or annoying to others. ☐
18. Sometimes, these individuals get into difficulty with co-workers or the police, during these high periods. ☐

19. Sometimes they increase their alcohol or non-prescription drug use during these periods.

A. Now that you have read this passage, please select one of the following four options:

- ☐ This story fits me very well, or almost perfectly.
- ☐ This story fits me fairly well.
- ☐ This story fits me to some degree, but not in most respects.
- ☐ This story doesn't really describe me at all.

B. Now go back and put a check after each sentence (numbered 1-19 above) that definitely describes you.

PTSD Checklist (PCL) **Directions:** For each item below, please indicate the answer that best describes your behaviors and experiences in the past 6 months

	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
1. Repeated, disturbing memories, thoughts, or images of a stressful experience?	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of a stressful experience?	☐	☐	☐	☐	☐
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	☐	☐	☐	☐	☐
4. Feeling very upset when something reminded you of a stressful experience?	☐	☐	☐	☐	☐
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience?	☐	☐	☐	☐	☐
6. Avoiding thinking about or talking about a stressful experience or avoiding having feelings related to it?	☐	☐	☐	☐	☐
7. Avoiding activities or situations because they reminded you of a stressful experience?	☐	☐	☐	☐	☐
8. Trouble remembering important parts of a stressful experience?	☐	☐	☐	☐	☐
9. Loss of interest in activities that you used to enjoy?	☐	☐	☐	☐	☐
10. Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	☐	☐	☐	☐	☐
12. Feeling as if your future will somehow be cut short?	☐	☐	☐	☐	☐
13. Trouble falling or staying asleep?	☐	☐	☐	☐	☐
14. Feeling irritable or having angry outbursts?	☐	☐	☐	☐	☐
15. Having difficulty concentrating?	☐	☐	☐	☐	☐
16. Being "super-alert" or watchful or on guard?	☐	☐	☐	☐	☐
17. Feeling jumpy or easily startled?	☐	☐	☐	☐	☐